BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: COLLIN B., Claimant, and INLAND REGIONAL CENTER, Service Agency.	OAH No. L 2006060023

DECISION

Gary Brozio, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, heard this matter in San Bernardino, California, on January 16, 2007.

Deborah K. Crudup, Consumer Services Representative, represented the Inland Regional Center (IRC).

Claimant's father represented him at the hearing. Claimant was not present.

The matter was submitted January 16, 2007.

ISSUES

Is Collin eligible for regional center services under a diagnosis of autism? If Collin meets the criteria for a diagnosis of autism, does his condition constitute a substantial disability that is likely to continue indefinitely?

FACTUAL FINDINGS

Background

1. Collin was born in Arizona on November 20, 1999. He now lives with his mother, father, and four siblings in Indio, California.

Collin's parents began to notice delays in Collin's development before he turned three. In late 2002, they took him to IRC for an assessment. IRC secured a social assessment, a medical assessment, and a psychological evaluation. In January 2003, a diagnostic team determined that Collin was not eligible for regional center services. Afterward, Collin's parents filed a request for hearing, that they later withdrew, and the matter was dismissed.

In January 2006, Collin's parents renewed their request for regional center services. Again, IRC secured a social assessment, a medical assessment, and a psychological evaluation. In March 2006, a diagnostic team determined that Collin was not eligible for regional center services. Collin's parents filed another request for hearing, and this hearing followed.

Criteria for Eligibility

2. Autism is included in the Lanterman Act as a developmental disability. (Welf. & Inst. Code, § 4512, subd. (a).) The criteria for a diagnosis of autism are set forth in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (*DSM-IV-TR*). To be diagnosed as autistic, Section 299.00 of the *DSM-IV-TR* requires that the person have:

> "A. A total of six (or more) items from [categories] (1), (2), and (3), with at least two from [category] (1), and one each from [categories] (2) and (3):
>
> (1) Qualitative impairment in social interaction, as manifested by at least two of the following:
>
> (a) Marked impairments in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;
>
> (b) failure to develop peer relationships appropriate to developmental level;
>
> (c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest);
>
> (d) lack of social or emotional reciprocity.
>
> (2) Qualitative impairments in communication as manifested by at least one of the following:
>
> (a) Delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime);

(b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others;

(c) stereotyped and repetitive use of language or idiosyncratic language;

(d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.

(3) Restricted repetitive and stereotyped patterns of behavior, interests and activities, as manifested by at least two of the following:

(a) Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus;

(b) apparently inflexible adherence to specific, nonfunctional routines or rituals;

(c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements);

(d) persistent preoccupation with parts of objects.

B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, (3) symbolic or imaginative play.

C. The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder."

3. To qualify for regional center services under the Lanterman Act, a person must not only have a qualifying diagnosis, but that person's developmental disability must also constitute a "substantial disability" which requires proof of at least three "significant functional limitations" in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency. California Code of Regulations, title 17, section 54001, repeats these requirements. The latter two categories (capacity for independent living and economic self-sufficiency) are not relevant to a seven-year-old child. The Lanterman Act also requires that a developmental disability be expected to continue "indefinitely." (Welf. & Inst. Code, § 4512, subd. (a).)

Collin's Medical, Psychological, and other Evaluations

4. Judy Morgan, M.S., CCC/SLP, a speech and language therapist, evaluated Collin on September 20, 2002. Morgan's report noted a lack of cooperation and the presence

of echolalia. She diagnosed Collin with Autism Spectrum Disorder (ASD). Morgan's expertise to render a psychological diagnosis was not clear.

5. Kathleen Hurwitz, M.D., a pediatric neurologist, evaluated Collin on September 23, 2002. Dr. Hurwitz's report stated that Collin appeared to be in his own little word, that he had poor eye contact, that he had expressive language delay, and that he had delays in social interactions. Dr. Hurwitz concluded that Collin did not "meet the DSM IV criteria completely for an autistic spectrum disorder."

6. Beth Nelson, an occupational therapist, performed an assessment on October 10, 2002. Her report noted Collin lacked some gross motor coordination. It also noted Collin's tendency to sort or categorize blocks, an under-responsiveness to touch, a poor understanding of boundaries, a propensity for over-stimulation from loud sounds, a need for a ritual at bedtime, and a preference for being under dressed. The report noted that Collin liked to swing, but was very particular about which swing he used and who pushed him. She concluded there was a concern about Collin's "insistence upon maintaining routine and difficulty with transitions." Much of the information in the assessment appeared to be based on parental report.

7. An intake counselor for IRC performed a social assessment of Collin on October 23, 2002. Among other things, the assessment noted that Collin had poor eye contact, tantrums, self-stimulating behavior (sucking on a blanket or his thumb), and a need for routines.

8. Alan Alexander, M.D., F.A.A.P., produced a hand-written note on December 5, 2005, stating that Collin had ASD and concluding that Collin required speech therapy. In an undated, single-page document, Dr. Alexander wrote that Collin had "high-functioning autism."

9. M.J. Gilbreath, a school psychologist, tested Collin on December 20, 2002 and prepared a report. The report indicated that Collin interacted with peers for short periods, but he preferred parallel play. Gilbreath administered the Gilliam Autism Rating Scale (GARS), which produced an autism quotient of 103 (average range for probability for autism). On the adaptive behavior tests, however, Collin scored in the average range for physical, self-help, academic, and social areas. His only below-average score was in communication. Gilbreath's report concluded that Collin demonstrated "significant speech and language delays with Autistic features."

10. Sarah Roddy, M.D., a pediatric neurologist, saw Collin on an unknown date and prepared a two-page letter on January 10, 2003. Dr. Roddy noted that Collin was receiving occupational therapy and speech and language therapy. Dr. Roddy's letter concluded that Collin had language delay and "some features that are seen in the autism spectrum disorder," but he was "having good progress in language and social skills."

11. Thomas F. Gross, Ph.D., evaluated Collin for IRC on January 23, 2003. During the testing, Dr. Gross observed that Collin made "eye contact which had social

quality" and had a "nice smile associated with it." Collin appeared to show pride in his accomplishments and sought attention for it. Dr. Gross saw "no odd, repetitive, or stereotypical behavior." Regarding communication, Dr. Gross noted that Collin had some good communication skills, but he did not ask "wh" questions, he did not typically initiate verbal interactions, he often repeated final words that he heard, and he tended to ignore others when spoken to. Regarding socialization, Dr. Gross noted that Collin saw his parents and family members as "significant others" and periodically sought their "attention and regard." Collin could be "distant and aloof," and, although he showed interest in other children, he did not "reliably initiate or sustain reciprocal and cooperative interactions with them." On intelligence testing, Dr. Gross gave Collin a composite standard score of 102. On the Childhood Autism Rating Scale (CARS), Dr. Gross scored Collin as 24, which was below the 29.5 score that is indicative of autism. Dr. Gross concluded that while Collin exhibited some features of autism (e.g. narrow and focused interest, some preservative and ritualized use of objects, difficulty sustaining joint activity with others), Collin did "not exhibit a sufficient number of features nor to such a degree that the diagnosis of autism is appropriate." Dr. Gross diagnosed Collin with mild Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS).

12. On October 14, December 1, and December 2, 2004, a multidisciplinary team from Desert Sands Unified School District conducted an assessment and prepared a report signed by school psychologist Vikki Nabozny. The report stated that Collin was a "friendly and playful child." He had a short attention span and some deficits in communication skills, but when he was observed in the classroom, Collin "seemed to be liked by the other students." Various tests were administered, including intelligence testing which resulted in a full-scale I.Q. score of 110. The report concluded that Collin's nonverbal intellectual functioning was in the high-average range, but his verbal intellectual functioning was in the low-average range. The report stated that Collin continued to display certain behaviors characteristic of ASD, but he had "improved since the last visitation." The report concluded that Collin's "educational needs [could] be met within the general education classroom at this time."

13. William M. Deering, M.D., filled out a prescription form on February 18, 2005. It gave a diagnosis of autism and requested a speech and language evaluation and therapy.

14. Steven Ashwal, M.D., a professor in pediatrics and neurology, wrote three letters regarding Collin. On August 3, 2005, Dr. Ashwal stated that Collin had a history of "behavioral problems, difficulties with attention span, an early history of delayed speech and some impairments of socialization." He noted, however, that Collin had made "great strides" over the past several years and he did not have "any evidence of impairments of social behavior or language delays" that had been present in his early childhood. Dr. Ashwal observed that Collin had "cyclical changes in his mood" and at times became extremely hyper-excitable, for which medication (Risperdal) was recommended. The doctor did not feel that a diagnosis of bipolar disorder was warranted at this point in time, nor did he diagnose Collin with autism. A few months later, on November 2, 2005, Dr. Ashwal wrote a two-page letter stating that he "suspected" Collin had an autistic spectrum disorder. He

suggested reevaluation by the school district and the regional center. Finally, on February 2, 2006, Dr. Ashwal wrote a one-page letter stating that Collin had autism spectrum disorder. No explanation was given to support Dr. Ashwal's change in diagnosis.

15. A senior intake counselor for IRC performed a second social assessment of Collin on February 2, 2006. It indicated that all of Collin's siblings, save one, had some sort of developmental problem. One was diagnosed with autism and another with bipolar disorder. The results were passed on to IRC's psychologist, Dr. Perez, and were considered in conjunction with Dr. Perez's testimony.

16. Rebecca Perez, Ph.D., saw Collin on March 8 and 29, 2006. Dr. Perez evaluated Collin, performed numerous tests, reviewed records and videotapes, and interviewed Collin's mother. Dr. Perez diagnosed Collin with PDD-NOS and concluded that he did not meet the *DSM-IV-TR*'s criteria for a diagnosis of autism. Her findings are discussed in conjunction with her testimony.

17. Marcey Utter, M.S., CCC-SLP, a speech and language pathologist evaluated Collin on March 12, 2006. Her report noted inconsistent eye contact, flat effect with few changes in expression, poor body language, and poor body control. Collin did smile and act silly on occasion. Collin lingered on topics that were of interest to him and had difficulty maintaining a topic of interest to the therapist. He showed a paucity of response. Ms. Utter concluded that Collin lacked the ability to shift his perspective to consider the therapist, and he lacked the ability to organize thoughts. Ms. Utter believed that Collin required therapy to improve his social skills.

18. Hilda A. Chalgujian, Ph.D., a clinical neuropsychologist, evaluated Collin on August 29, 2006. Dr. Chalgujian did not testify at the hearing.[1] Her report indicated that she interviewed Collin, reviewed numerous records (but not the reports of Dr. Hurwitz, Dr. Roddy, or Dr. Perez), and conducted numerous tests for intellectual functioning (but no specific tests for adaptive functioning or autism). No evidence was presented to establish Dr. Chalgujian's experience in assessing autistic children. Dr. Dr. Chalgujian's report stated that Collin's overall intellectual functions were within normal limits, but his response style was fidgety, inattentive, distractible, and impulsive. Among other things, the doctor saw Collin rock back and forth, shake his head, suck his thumb, and cling to his blanket. She observed frequent echolalia and parlilalia. Her report noted that Collin lingered on topics that interested him, and that he had difficulty maintaining topics of interest to the doctor. He had inconsistent eye contact and poor body language. He talked to the wall and floor and stared out the window. Testing revealed average intelligence with particular strength in reasoning

[1] At the beginning of the hearing, Collin's father stated that Dr. Chalgujian was available to testify by telephone and could be reached all day. The ALJ told Collin's father to telephone Dr. Chalgujian and inform her that her testimony would be taken after the lunch break. Collin's father stated that he left the doctor a message to that effect. After the lunch break, the hearing was moved to another room to permit the taking of telephonic testimony. At this time, Claimant's father and IRC staff made numerous telephone calls to Dr. Chalgujian and left messages, but she did not answer the calls or respond to the messages. Thereafter, the ALJ took the testimony of Collin's father, and a final attempt was made to contact the doctor. Again, the doctor did not respond and the hearing was concluded at 2:30 p.m.

and visuospatial/constructive functions. Other areas were generally within normal limits, with the weakest performance in academic knowledge and executive functions (attention and concentration). Based on the Rorschach ink-blot testing, Dr. Chalgujian opined that Collin had "an adequate sense of himself" and was "well-integrated into his family system," but he showed some underlying depression, dejection, and anxiety short of "acute psychosis." Dr. Chalgujian opined that Collin's behaviors showed qualitative impairment in social interactions and communication, as well as restrictive repetitive and stereotype patterns of behavior. She diagnosed Collin with Autistic Disorder.

19. The record contains several of Collin's Individualized Education Programs (IEP). All IEPs listed "Speech or Language Impairment" as the disability category, and two of them added autism as an additional disability. Collin has always been in a general-education class supplemented with speech, occupational and other therapies and supports. He has not received any treatments such as Applied Behavioral Analysis.

Dr. Perez's Testimony

20. Dr. Perez was formerly employed as a staff psychologist by IRC, but she left that employment to pursue a school psychologist credential. Presently, she is vendored to the regional center as a psychologist. She has performed over 800 assessments for autism. She was well-qualified to render an opinion.

Dr. Perez reviewed records, interviewed Collin's mother, tested Collin, and viewed some home videos. She prepared a report, and in her testimony she assessed the reliability of Dr. Chalgujian's report. She concluded that Collin's mother reported symptoms consistent with PDD-NOS, but that Collin did not meet the *DSM-IV-TR*'s criteria for Autistic Disorder. While Collin displayed some restricted repetitive and stereotyped patterns of behavior and some qualitative impairment in communication, he did not display the requisite qualitative impairments in social interaction. As Dr. Perez explained, Collin's impairment in the use of multiple nonverbal behaviors (such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction) were not "marked;" he did not show a "failure" to develop peer relationships appropriate to developmental level; he did not show a "lack" of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest); and he did not "lack" social or emotional reciprocity. In short, Collin's deficits in social interaction were not severe enough to warrant a diagnosis of Autistic Disorder.

Dr. Perez's testimony was persuasive for a number of reasons. First, Dr. Perez's testing was specifically designed for autism. Dr. Perez administered the Autism Diagnostic Observation Schedule, Module 3 (ADOS). The ADOS is the "gold standard" in for testing for autism because, unlike the Childhood Autism Rating Scale (CARS) and the GARS tests that rely on parental report and can produce unrepresentative scores, the ADOS test requires interaction between the evaluator and the child.[2] Thus, the ADOS is based on the

[2] This case presented concerns about the reliability of the parental reports on the CARS test because, prior to Dr. Perez's examination of Collin, Collin's parents obtained a copy of the CARS test and self-administered it. Dr.

observations of a trained psychologist. Collin received a score of 3 on the ADOS, which does not fall within the autistic range. Dr. Perez also noted that Dr. Gross's administration of the CARS test in 2003 (which occurred before the parents' self-administration of the CARS test), produced a score below the level required for autism. Taken together, these tests showed that Collin had social capabilities that were inconsistent with a diagnosis of autism.

Second, Dr. Perez did not observe significant social deficits in Collin's behavior during the assessment. Collin was socially responsive, he performed joint referencing, and he made eye contact. He spontaneously played with toys and allowed Dr. Perez to join in play. He enjoyed action figures and make-believe play. He participated in story telling and made good use of creativity, gesture, and emotional words. He was talkative and asked appropriate questions. He gave age-appropriate answers about his emotions and feelings. He told Dr. Perez about his friend named Tanner, and he was able to describe what they did and why they were friends. Collin displayed no echolalia or pronoun confusion. His speech had normal tone and rhythm. He did not get stuck on topics. He conversed and used gestures. Moreover, Dr. Perez viewed some home videos that showed Collin engaging in normal social interaction.[3] These observations supported the results of the testing.

Third, Dr. Perez placed little weight on the medical reports that did not describe Collin's behavior, that were not based on appropriate testing, and that contained a diagnosis not based upon the *DSM-IV-TR* criteria. Dr. Perez explained that autism is difficult to diagnose and differentially diagnose. A reliable diagnosis cannot be procured without appropriate testing designed to elucidate the criteria in the *DSM-IV-TR*, which does not contain a diagnosis of Autism Spectrum Disorder. Dr. Perez also pointed out that Dr. Ashwal changed Collin's diagnosis over the course of a few months without explanation, which undercut the reliability of Dr. Ashwal's diagnosis.

Fourth, Dr. Perez believed Dr. Chalgujian's report contained serious flaws. Dr. Chalgujian tested mainly for intelligence (and confirmed the undisputed fact that Collin has generally average or above average intelligence), but she did not conduct any testing specifically designed to diagnose autism. Dr. Perez would not render a diagnosis of autism based on intelligence and memory scores, and she could not see how Dr. Chalgujian could reliably render such a diagnosis based on the testing she administered. Dr. Chalgujian also failed to review all of the available reports, most notably Dr. Perez's report that contained specific testing for autism.

Perez explained that this undercut the reliability of the parents' CARS test, and any subsequent CARS tests, because the questions in the CARS test were designed to be completed by a qualified professional while interviewing the parents. Dr. Perez explained that the CARS test is far more complicated than it appears and considerable training is required to make an accurate assessment. For these reasons, no weight was given to the CARS tests that the parents administered themselves.

[3] During the assessment, Collin's mother explained that the videos were taken at a time when Collin was behaving well. The mother never took videos when Collin was behaving badly because she was too busy dealing with the behavior. While this may be true, it did not undercut the fact that Collin could behave in a fairly normal social fashion.

Dr. Perez conducted testing for adaptive functioning and, in response to the ALJ's questions, she rendered an opinion on the issue of substantial disability. Dr. Perez concluded that Collin had disability in the areas of self-care (daily living skills) and receptive and expressive language, but Collin was not substantially disabled in the areas of mobility, learning, and self-direction. Dr. Perez was unable to render a diagnosis that explained Collin's deficits, but she speculated that the cyclical nature of Collin's behavior, the nature of his deficits, the reference in some reports to the possibility of bipolar disorder, and his family history might convey early signs of a mental health problem. It was too early, however, to make that diagnosis.

Collin's Father's Testimony

21. Collin's father testified at the hearing. He was obviously a devoted and caring father. He testified that Collin seldom exhibited all the traits of autism in one sitting or in any one test, but he believed that all the facts taken together painted a picture of autism and met the *DSM-IV-TR*'s criteria for Autistic Disorder. Collin's father submitted a sheet of paper with all the traits he had observed in his son (Exh. 51). He went through the reports and pointed out where trained professionals recorded personal observations or parental reports confirming these traits. These portions of the reports were included in the previous Factual Findings.

According to Collin's father, Collin appeared normal until 18 months of age. His vocabulary then decreased and he became more withdrawn. The deficits became more pronounced as he got older, and at age two-and-one-half, Collin was not where he should have been in speech and other areas. He began receiving various therapies, and the family began treating him differently. This treatment helped Collin greatly, and his symptoms decreased. It was around this time that Collin was first seen by IRC, which, in the father's opinion, resulted in Dr. Gross' rather benign report.

The father described Collin's difficulties in maintaining peer relationships. In first grade, Collin had trouble going to class, took his shoes off, and had sensory issues. He was not invited to birthday parties, and only two children came to his party even though 12 children were invited. This year in second grade, Collin made one friend named Tanner, who was the first child to invite Collin to a birthday party. The father reported that Collin often seemed in his own world. Collin sometimes licked students and showed poor understanding of boundaries in games like tag. This made Collin an outcast at school. In sports like soccer, Collin often became hypersensitive to heat and he did not understand the relationship he should have with teammates. Overall, Collin did not act appropriately in social relationships.

The father highlighted some of Collin's unusual behaviors, including rocking and swaying in times of anxiety, stuttering and repeating words when he did not know what to say, and carrying, rubbing, and smelling his blanket as self-calming activity.

Collin experiences constipation when he is stressed, and on one occasion he landed in the hospital when the stress from school caused him to vomit.

Collin's father explained that Collin's younger brother had been accepted as a client by IRC under a diagnosis of autism. The father felt that Collin's autistic features were more prevalent than his brother's.

Collin's father explained that his son's autistic symptoms were "cyclical." At times Collin does very well and does not display rocking or speech problems, after which he reverts back to the problematic behaviors.

LEGAL CONCLUSIONS

The Lanterman Act

1. The Lanterman Developmental Disabilities Services Act (Act) is set forth in the Welfare and Institutions Code. (Welf. & Inst. Code, § 4500 et. seq.) The purpose of the Act is to provide a "pattern of facilities and services . . . sufficiently complete to meet the needs of each person with *developmental disabilities*, regardless of age or degree of handicap, and at each stage of life." (§ 4501; *Association of Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384, 388 (emphasis added).)

Developmental Disability

2. Section 4512, subdivision (a) of the Act defines a developmental disability as follows:

> "(a) 'Developmental disability' means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a *substantial disability* for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature." (Emphasis added.)

3. Section 54000 of Title 17 of the California Code of Regulations further defines the term developmental disability:

> "(a) 'Developmental Disability' means a disability that is attributable to mental retardation, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.
>
> (b) The Developmental Disability shall:

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

(3) Constitute a substantial disability for the individual as defined in the article.

(c) Developmental Disability shall not include handicapping conditions that are:

(1) Solely psychiatric disorders where there is impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder. Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have become seriously impaired as an integral manifestation of the disorder.

(2) Solely learning disabilities. A learning disability is a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized mental retardation, educational or psycho-social deprivation, psychiatric disorder, or sensory loss.

(3) Solely physical in nature. These conditions include congenital anomalies or conditions acquired through disease, accident, or faulty development which are not associated with a neurological impairment that results in a need for treatment similar to that required for mental retardation."

4. The definition of Autistic Disorder contained in Factual Finding 2 is incorporated into these Legal Conclusions.

Substantial Disability

5. Section 4512, subdivision (l) of the Act defines a substantial disability as follows:

"(l) 'Substantial disability' means the existence of *significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person*:

(1) Self-care.

(2) Receptive and expressive language.

(3) Learning.

(4) Mobility.

(5) Self-direction.

(6) Capacity for independent living.

(7) Economic self-sufficiency.

Any reassessment of substantial disability for purposes of continuing eligibility shall utilize the same criteria under which the individual was originally made eligible." (Emphasis added.)

6. Section 54001 of Title 17 of the California Code of Regulations further defines the term substantial disability:

"(a) "Substantial disability" means:

(1) A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and

(2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:

(A) Receptive and expressive language;

(B) Learning;

(C) Self-care;

(D) Mobility;

(E) Self-direction;

(F) Capacity for independent living;

(G) Economic self-sufficiency.

(b) The assessment of substantial disability shall be made by a group of Regional Center professionals of differing disciplines and shall include consideration of similar qualification appraisals performed by other interdisciplinary bodies of the Department serving the potential client. The group shall include as a minimum a program coordinator, a physician, and a psychologist.

(c) The Regional Center professional group shall consult the potential client, parents, guardians/conservators, educators, advocates, and other client representatives to the extent that they are willing and available to participate in its deliberations and to the extent that the appropriate consent is obtained.

(d) Any reassessment of substantial disability for purposes of continuing eligibility shall utilize the same criteria under which the individual was originally made eligible."

7. California Code of Regulations, title 17, section 54002 states that "'Cognitive' as used in this chapter means the ability of an individual to solve problems with insight, to adapt to new situations, to think abstractly and to profit from experience."

8. The authorities regarding substantial disability and duration contained in Factual Finding 3 are incorporated into these Legal Conclusions.

Burden of Proof

9. In a proceeding to determine eligibility, the burden of proof is on the claimant to establish he or she meets the proper criteria. The standard is a preponderance of the evidence. (Evid. Code, § 115.)

The Evidence Was Not Sufficient to Establish that Collin is Eligible for Regional Center Services

10. Although Collin certainly exhibits some features seen in autistic children, the evidence failed to establish that he met the *DSM-IV-TR*'s criteria for Autistic Disorder. Specifically, claimant failed to prove that he has social deficits that meet the *DSM-IV-TR*'s criteria in Subpart A(1). Dr. Perez persuasively testified that her testing for autism, her review of the records (most notably Dr. Gross's report), and her personal observations revealed that Collin does not have qualitative impairments in social interaction. Collin certainly has challenges in the social arena, but his deficits are not severe enough to warrant a diagnosis of Autistic Disorder.

Claimant also failed to establish that he had a substantial disability in three of the several areas of major life activity as required by the Lanterman Act, or that his disability was likely to persist. Claimant presented no expert testimony on these issues, and the overall record demonstrated that Collin responds well to treatment which results in a significant decrease in his symptoms.

Dr. Chalgujian's report was not sufficient to carry claimant's burden of proof. It was not based on the testing best designed to detect autism. It failed to consider all of the relevant documents, including Dr. Perez's report that included the results of testing specifically designed to detect autism. No evidence was presented regarding Dr. Chalgujian's experience in assessing children for autism. She did not testify, and there was no explanation why her diagnosis should be considered more reliable than Dr. Perez's.

Finally, Dr. Chalgujian's report did not adequately address the questions of substantial disability or duration.

Mr. Gilbreath's results on the GARS test suffered from similar deficiencies. He did not testify and his qualifications were not established. Further, the GARS test was based on parental report, is not as reliable as the ADOS test, and was not sufficient by itself to render a diagnosis of autism. Mr. Gilbreath also failed to render a diagnosis of Autistic Disorder, and he did not address the questions of substantial disability or duration.

For the reasons given by Dr. Perez, none of the other medical reports were sufficient by themselves or in combination to produce a reliable diagnosis of Autistic Disorder. And since none of the professionals who produced those reports testified, it would be entirely speculative to judge what weight, if any, should be given to the various conclusions regarding Collin's diagnosis, the degree of his disability, or its duration.

Finally, Collin's father's testimony was insufficient to establish eligibility. Autism is exceedingly difficult to diagnose, and in a case such as this, lay opinion is not sufficient. Of great concern was the "cyclical" nature of Collin's symptoms in general, the waxing and waning of specific symptoms, and his ability to function relatively well at home and at school at various times. These matters cast serious doubt on the father's position that all the facts, when taken together, warrant a diagnosis of autism.

These Conclusions are based on all the Factual Findings and Legal Conclusions.

ORDER

The IRC's denial of services under the Lanterman Act is upheld.

DATED: _____

_____
GARY BROZIO
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision; both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.